STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 01 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARSAW MEADOWS CARE CENTER	300 E PRAIRIE ST WARSAW, IN46580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/18/11 Facility Number: 000359 Provider Number: 155566 AIM Number: 100274920 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Warsaw Meadows Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type III (211) construction in the original	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	building and the northwest, west and laundry wings were of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 100 and had a census of 67 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 04/27/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=E	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. 1, Based on observation and interview, the facility failed to ensure 1 of 14 resident room doors protecting corridor openings on Harmony hall would close and latch into the door frame. This deficient practice could affect any of the 15 residents on the Harmony hall. Findings include: Based on observation with the Maintenance Director on 04/18/11 at 1:35 p.m., the corridor door to resident room 15 failed to latch into the door frame. This was acknowledged by the Maintenance Director at the time of observation.	K0018	**This plan of correction is to serve as Warsaw Meadows Care Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Warsaw Meadows Care Center or its management company of any conclusion set forth in the statement of deficiencies or any violation of regulation. K018 NFPA 101 Life Safety Code Standard It is the practice of Warsaw Meadows Care Center to ensure that it provides the best care possible. In accordance with that policy, we have addressed the following issues: A. The resident's bed in room 15 on Harmony Hall was causing the corridor door to not close and latch into the door frame. Bed was moved to ensure door closes and latches into the**	05/18/2011

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 13 doors protecting corridor openings were smoke resistive in Memory Lane. This deficient practice could affect all 21 residents in Memory Lane. Findings include: Based on an observation with the Maintenance Director on 04/18/11 at 1:50 p.m., there were four pencil size holes near the top of the corridor door to resident room 36 on Memory Lane. This was confirmed by the Maintenance Director at the time of observation. 3.1-19(b)		**door frame on 05/04/2011. The corridor door to resident room on Memory Lane was fixed on 4/19/2011 and no longer has four pencil size holes near the top. No negative outcomes were found that could have affected any of the residents. B. An Audit tool was created on 05/04/2011 to ensure that all doors are being checked for holes and are providing the proper smoke barrier per Life Safety Standard. The Audit tool is also used to ensure that no one is putting trash containers, beds, or any other items in front of the doors that would cause the door not to close and latch into the door frame. A Monthly Environmental Rounds tool was created that the Maintenance Director and Administrator will use together each month for the Safety Committee Inspection. C. The Maintenance Director has been educated to the use of the new Audit tool and Monthly Environmental Rounds tool. All employees were provided education on smoke barriers, and ensuring beds, curtains, trash containers, etc are not left in front of doors, and the proper procedures for notifying the Maintenance Director or designee if issues are discovered. This was**	

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			completed on May 9, 2011. D. The Maintenance Director will audit all the doors prior to May 18, 2011. The Maintenance Director will provide results from the new Audit tool to the Administrator for review. Results of the Monthly Environmental Rounds and the new Audit tool will be reviewed monthly by the Quality Assurance Committee and overseen by the Administrator to ensure continued compliance. E. The Administrator is responsible. We will be in compliance by May 18, 2011.	
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 3 of 3 hazardous areas, such as water heater rooms and combustible storage areas over 50 square feet in size, were self closing and latched into the door frame. This deficient practice could affect	K0029	**K029 NFPA 101 Life Safety Code Standard A. A self closing device was installed to the corridor door to the water heater room in the Administrator hall on 05/10/2011. A new self closing device was installed to the corridor door to the water heater room in the Memory Lane that was missing a**	05/18/2011

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	residents in the Administration hall, Memory Lane and the north Central hall. Findings include: Based on an observations with the Maintenance Director on 04/18/11 from 1:06 p.m. to 2:00 p.m., the following was noted: a) the corridor door to the water heater room in the Administrator hall was not equipped with a self closing device. b) a screw was missing from the self closing device on the corridor door to the water heater room in the Memory Lane and it was no longer functional. c) the corridor door to the Medical record/storage room containing cardboard boxes of medical records did self close, but failed to latch into the frame. These problems were confirmed by the Maintenance Director at the time of observations. 3.1-19(b)		**screw. This was completed on 04/20/2011. The corridor door to the Medical record/storage room, containing cardboard boxes of medical records, was fixed on 04/27/2011 so that it now latches into the frame. No negative outcomes were found that could have affected any of the residents. B. An Audit tool was created on 5/04/2011 to ensure that all hazardous doors have been identified and have a self-closing device in place. C. The Maintenance Director was educated to the use of the new Audit tool. All employees received education on the importance of filling out a maintenance request form as soon as possible to ensure that all issues are handled promptly by the Maintenance Director or designee. This was completed on May 9, 2011. D. The Maintenance Director and Administrator will inspect all hazardous areas the first week, then will inspect monthly during the Safety Committee Inspection, using the Monthly Environmental Rounds tool. Results of the Monthly Environmental Rounds and the new Audit tool will be reviewed monthly by the Quality Assurance Committee and overseen by the Administrator to ensure continued compliance. E. The**	

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			Administrator is responsible. We will be in compliance by May 18, 2011	
K0046 SS=C	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation and record review, the facility failed to ensure 14 of 14 emergency lights were tested annually for at least a 1 1/2 hour duration in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency light for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on observations with the Maintenance Director on 04/18/11 from 12:55 p.m. to 3:00 p.m., fourteen battery operated emergency lights were observed throughout the facility.	K0046	**K046 NFPA 101 Life Safety Code Standard** **A. All fourteen battery operated emergency lights will be tested by May 18, 2011.** **No negative outcomes were found that could have affected any of the residents.** **B. An annual emergency light test tool was developed identifying each emergency light and that at least 1 ½ hour duration is provided in accordance with Life Safety Code 7.9. Task to ensure annual testing is done was added to the Environmental Rounds Tool checklist for December of every year.** **C. The Maintenance Director was educated on the new Annual Emergency Light Test tool.** **D. The Maintenance Director will provide results from the Audit tool to be reviewed monthly by the Quality Assurance Committee and**	05/18/2011

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	Emergency lights were tested during tour of the facility and worked. During record review at 12:55 p.m. on 04/18/11, the Maintenance Director failed to provide a written record of an annual test regarding the battery operated emergency lights. 3.1-19(b)		**overseen by the Administrator to ensure continued compliance.** **E. The Administrator is responsible. We will be in compliance by May 18, 2011**	
K0056 SS=E	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure 2 of 2 sprinklers in the smoking room were separated by at least six feet as required by NFPA 13. NFPA 13, Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect any	K0056	**K056 NFPA Life Safety Code Standard** **A. 1 of the 2 sprinklers located in the smoking room has been removed in order to meet the required Life Safety Code Standard. This was completed on 05/03/2011.** **No negative outcomes were found that could have affected any of the residents.**	05/18/2011

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	residents in the smoking room and the Center hall north in the event of an emergency. Findings include: Based on an observation with the Maintenance Director on 04/18/11 at 2:05 p.m., the smoking room had two sprinklers located five feet apart. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)		**B. All sprinklers throughout facility will be inspected to ensure they meet Life Safety Code specifications.** **C. The Maintenance Director will be educated to procedure and documentation by 5/13/2011.** **D. An Audit of all sprinklers throughout facility will be conducted to ensure all sprinklers are inspected by May 18, 2011 to ensure they meet Life Safety Code specifications. The sprinkler heads will then be inspected weekly x 4 weeks, then monthly for 5 months and ongoing. The Maintenance Director will provide documentation of inspections to be reviewed monthly by the Quality Assurance Committee and overseen by the Administrator to ensure continued compliance.** **The Administrator is responsible. We will be in compliance by May 18, 2011**	
K0130 SS=E	OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure 2 of 3 penetrations of the fire barrier walls on the	K0130	**K130 NFPA101 Miscellaneous** **A. There were two unsealed penetrations around a sprinkler line measuring three inches and around a conduit pipe**	05/18/2011

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	Administration hall and Harmony hall were protected by an approved device designed for the specific purpose and capable of maintaining the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the		**measuring one inch. There is no longer a penetration. There was an unsealed penetration measuring one inch around a sprinkler line. There no longer is a penetration. B. A tool was created to ensure that pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected per Life Safety Code standards. C. The Maintenance Director was educated on the Life Safety Code 8.2.2.2.4.2 requirements. A Protocol was developed that the Maintenance Director will follow any vendor contracted that provides work in the attic to ensure there are no unsealed penetrations. D. The Maintenance Director will audit all areas of potential concern prior to May 18, 2011 and then weekly for 4 weeks, then monthly for 5 months and then ongoing. The Maintenance Director will provide results to be reviewed monthly by the Quality Assurance Committee and overseen by the Administrator to ensure continued compliance.E. The Administrator is responsible. Date of compliance is May 18, 2011.**	

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	sleeve shall meet on of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect all residents in the front office area of the Administration hall and 15 residents on Harmony hall. Findings include: Based on observations with the Maintenance Director on 04/18/11 from 2:45 p.m. and 3:00 p.m., the following penetrations were in both attic fire barrier walls of the Administration hall and Harmony hall: a) at the attic fire barrier wall on the Administration hall there were two unsealed penetrations around a sprinkler line measuring three inches and around a conduit pipe measuring one inch. b) at the attic fire barrier wall entering Harmony hall from the Administration hall there was an unsealed penetration measuring one inch around a sprinkler line.			

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	Based on an interview with the Maintenance Supervisor at the time of observation, the walls were fire barrier walls. 3.1-19(b)			
K0144 SS=C	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to provide the complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.1.1.8 requires the generator set shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice affects all occupants Findings include: Based on review of the "Generator Audit" log with the Maintenance Director on 04/18/11 at 12:40	K0144	**K144 NFPA 101 Life Safety Code Standard** **A. A stopwatch was purchased to ensure monthly load test record indicating the transfer of power from the main source to the emergency generator doesn't take longer than 10 seconds.** **No negative outcomes were found that could have affected any of the residents.** **B. The Maintenance Director contacted Dickerhoff Electric, the vendor who inspects our generator, and they instructed the Maintenance Director as to how to adjust it. A monthly load test log was created to ensure the transfer of power from the main source to the emergency generator is not taking any more than 10 seconds.**	05/18/2011

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	p.m., the monthly load test record indicated the transfer of power from the main source to the emergency generator took more than ten seconds for the months of February and March 2011. This was confirmed by the Director of Maintenance at the time of record review. 3.1-19(b)		**C. The Maintenance Director was educated to the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power.** **D. The Maintenance Director will provide monthly load test to the Administrator for review and signature. The Maintenance Director will provide all information from log to be reviewed monthly by the Quality Assurance Committee and overseen by the Administrator to ensure continued compliance.** **E. The Administrator is responsible. We will be in compliance by May 18, 2011**	